DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18247

State File No.

FILED MAY 20 1943

Registration District No. 172

Primary Registration District No. 9161

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Dover - Dover Twp

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural 11 mi. E. Lex

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community 3 wks. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 54

(a) State Mo. (b) County Lafayette

(c) City or town Dover, Mo

(If outside city or town limits, write "RURAL")

(d) Street No. 11 mi. E. Lex. Mo

(If rural, give location)

(e) Citizen of foreign country? (Yes or No) U

If yes, name country

3. (a) PRINT FULL NAME BIRDIE Scharnhorst

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clarence Scharnhorst

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 11 (Day) 1911 (Year)

8. AGE: Years 31 Months 10 Days 3 If less than one day hr. min.

9. Birthplace Carroll Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Chas Finley

13. Birthplace Carroll, Co. (City, town, or county) Mo (State or foreign country)

14. Maiden name Not Known

15. Birthplace " " (City, town, or county) " (State or foreign country)

16. (a) Informant Clarence Scharnhorst

(b) Address Lexington, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-43 (Month) (Day) (Year)

(c) Place: burial or cremation Sweet Springs, Mo

18. (a) Signature of funeral director Winkler

(b) Address Lexington Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17

year 1943 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from , 19 , to April 17, 1943

that I last saw her alive on April 17 th 1943

and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Embolism	8 Hrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Child birth Mar 27-43	

Major findings:

Of operations 1/4 d

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature G. M. Kendall (M. D. or other)

Address Cordin Mo Date signed 4-18-43

(Licensed Embalmer's Statement on Reverse Side)

[illegible] District No. 8,
District File Number ----------
Date Filed 5-2-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....,
working under my personal supervision.

Signed Lucia M. McSwain

Licensed Embalmer No. 2983

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
V. [illegible] I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. M-C-

Registration District No. 172 Primary Registration District No. S-641 Registrar's No.

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Birdie Scharnhorst
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 11 (Month) (Day) (Year)

8. AGE: Years 31 | Months 10 | Days | If less than one day min.

9. Birthplace Carrollton (City, town, or county) Mo. (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 1-31-1943 (Date received local registrar) (b) Dr. W. A. Brackett (Registrar's signature)

SUPPLEMENTARY 1/7

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Embolism	6 hrs
Due to	
Due to	
Other conditions Child birth - 1/27/43 (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

S-18247